



**Health Reform and Reimbursement for Retail Health
Clinics
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United HealthCare**

This session

- UnitedHealth Group
- Affordable Care Act
- Accountable Care Organizations
- Patient Centered Medical Homes
- Where Convenience Care Clinics fit into it all

UnitedHealth Group Overview

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3

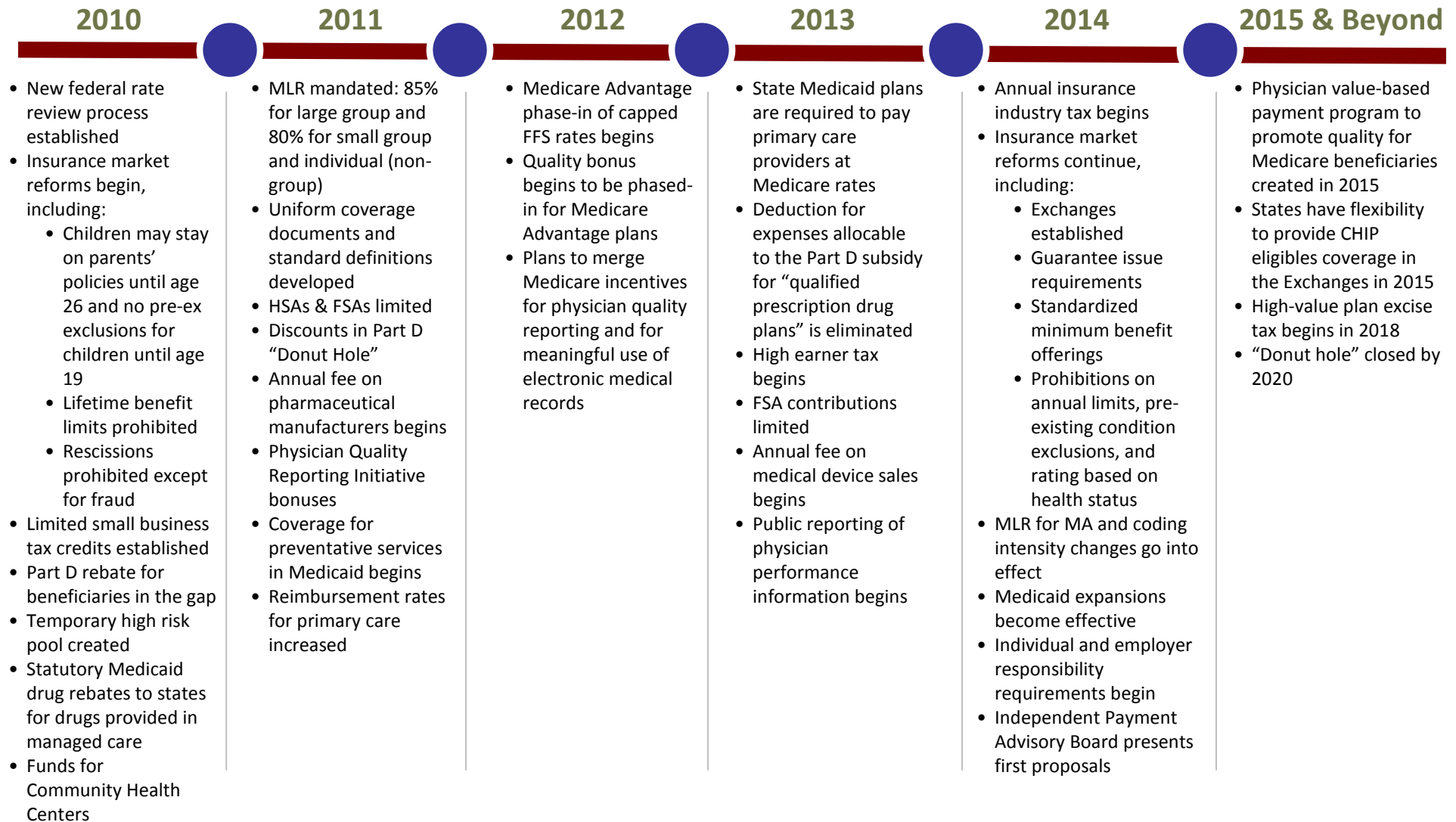
- Our mission: “to help people live healthier lives”
- UnitedHealth Group serves more than 70 million Americans each year
- UHG partners with:
 - 650,000 physicians and other care providers
 - 5,200 hospitals
 - 80,000 dentists
 - 65,000 pharmacies



Timeline of Key Elements: The Patient Protection and Affordable Care Act

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4

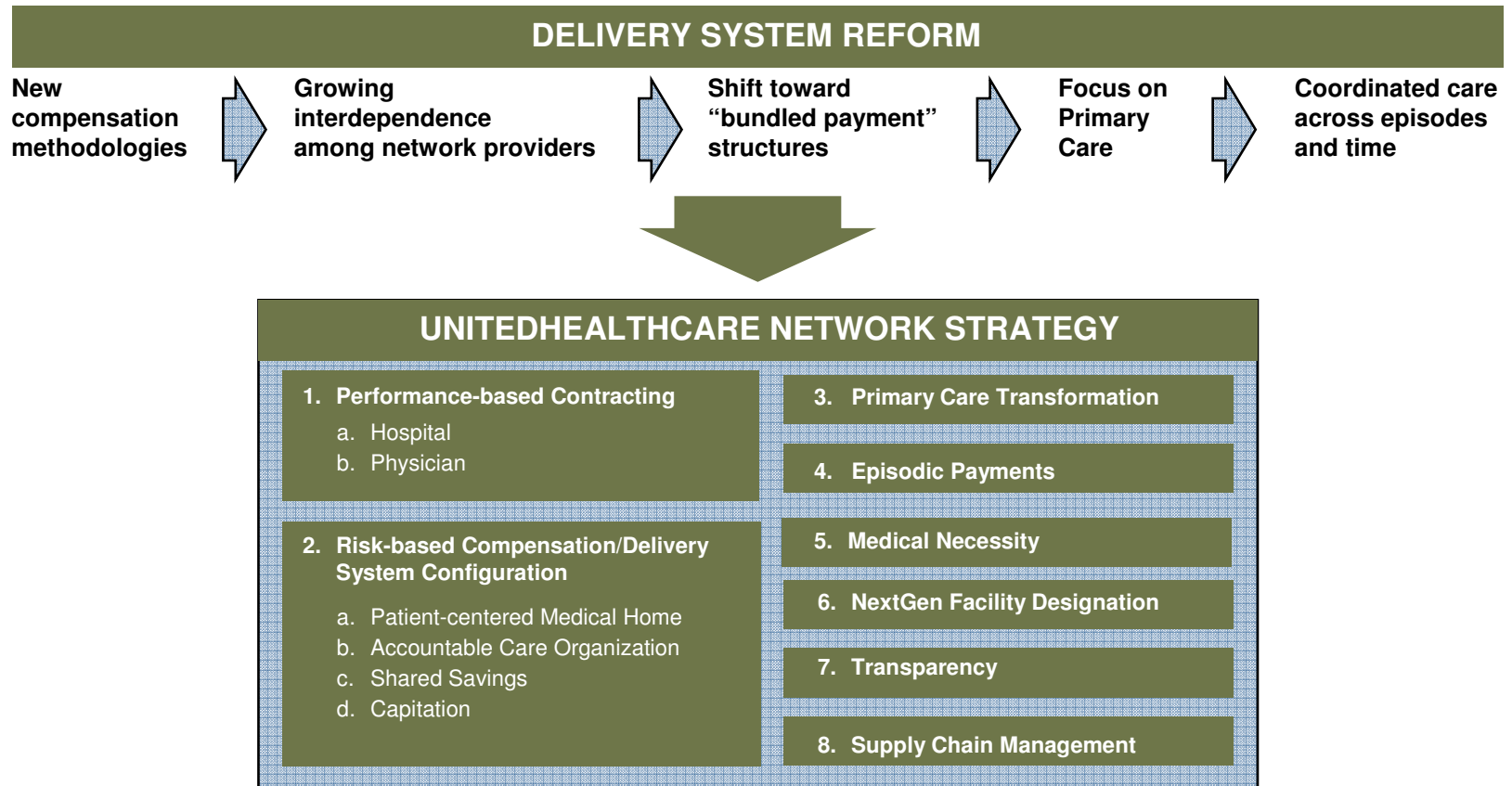




Value-based Contracting and Accountable Care

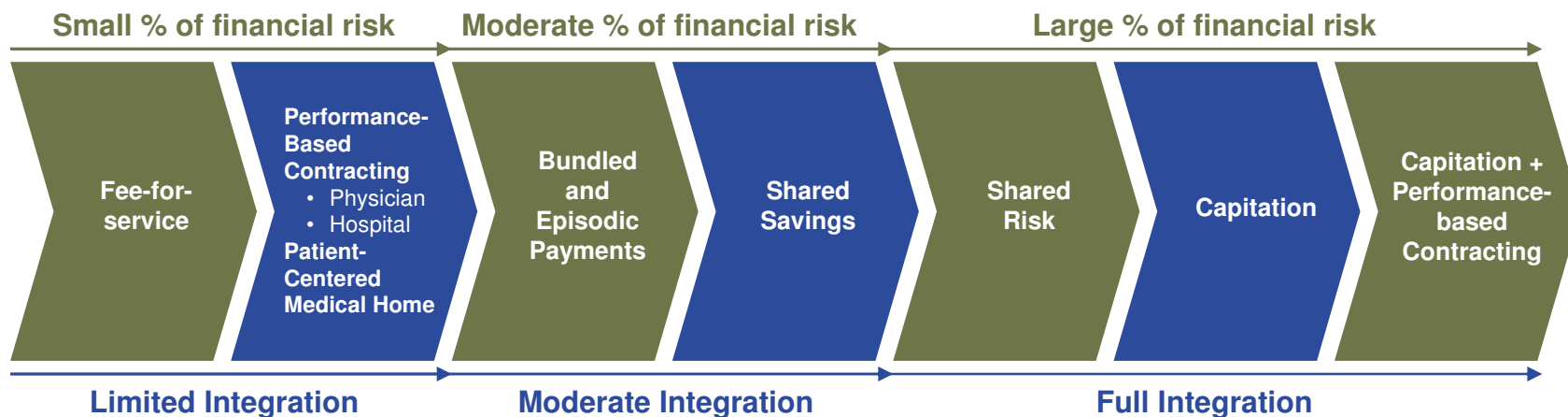
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Implications of delivery system reform



Evolving payment and delivery system models

Compensation Continuum (Level of Financial Risk)



Continuum of risks represents multiple value-based contracting options. UnitedHealthcare is working to deploy a variety of options with its network of providers based on their readiness to accommodate varying levels of risk.

Provider incentive models in place today on a selective basis:

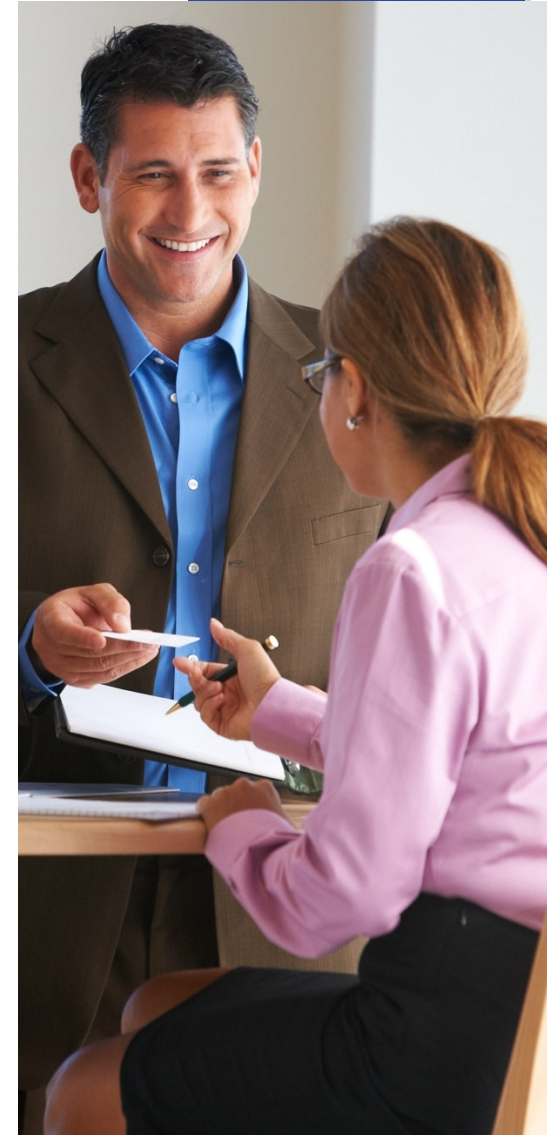
- Performance-based Contracting
- Patient-centered Medical Home
- Episodic and Bundled Payments
- Shared Savings
- Shared Risk
- Capitation

Today, in excess of 11.4% of our total spending on health care services, across all UnitedHealthcare lines of business, is tied to incentive contracts that reward providers for increased collaboration, outcome-based results and improved cost-efficiencies.

Evolution toward shared risk

The shift toward increased collaboration, outcome-based payment and new benefit design is driving innovation in terms of both payment models and delivery system configuration.

- Provider implications:
 - ✓ Increasing focus on integrated, population-level care coordination, with chronic care/disease management emerging as a vital competency
 - ✓ Improvement in total cost is an industry imperative
 - ✓ Greater alignment between primary care physicians and specialists
 - ✓ Greater alignment between hospitals and physicians
 - ✓ Increased clinical data sharing via health care information technology
 - ✓ Stronger relationships across the care continuum



Our value-based contracting approach

- Primary care transformation
- Performance-based contracting
- Patient-centered medical home models
- Episodic and bundled payments
- Shared savings / Shared risk models
- Accountable care organization partnerships (ACOs)
- Capitation + performance-based contracting
- Product strategies that incorporate network strategy

Accountable care focus: The UnitedHealthcare difference

Competitors

- Many plans indicate they are developing ACO models, although the structure may be a simple pay for performance program

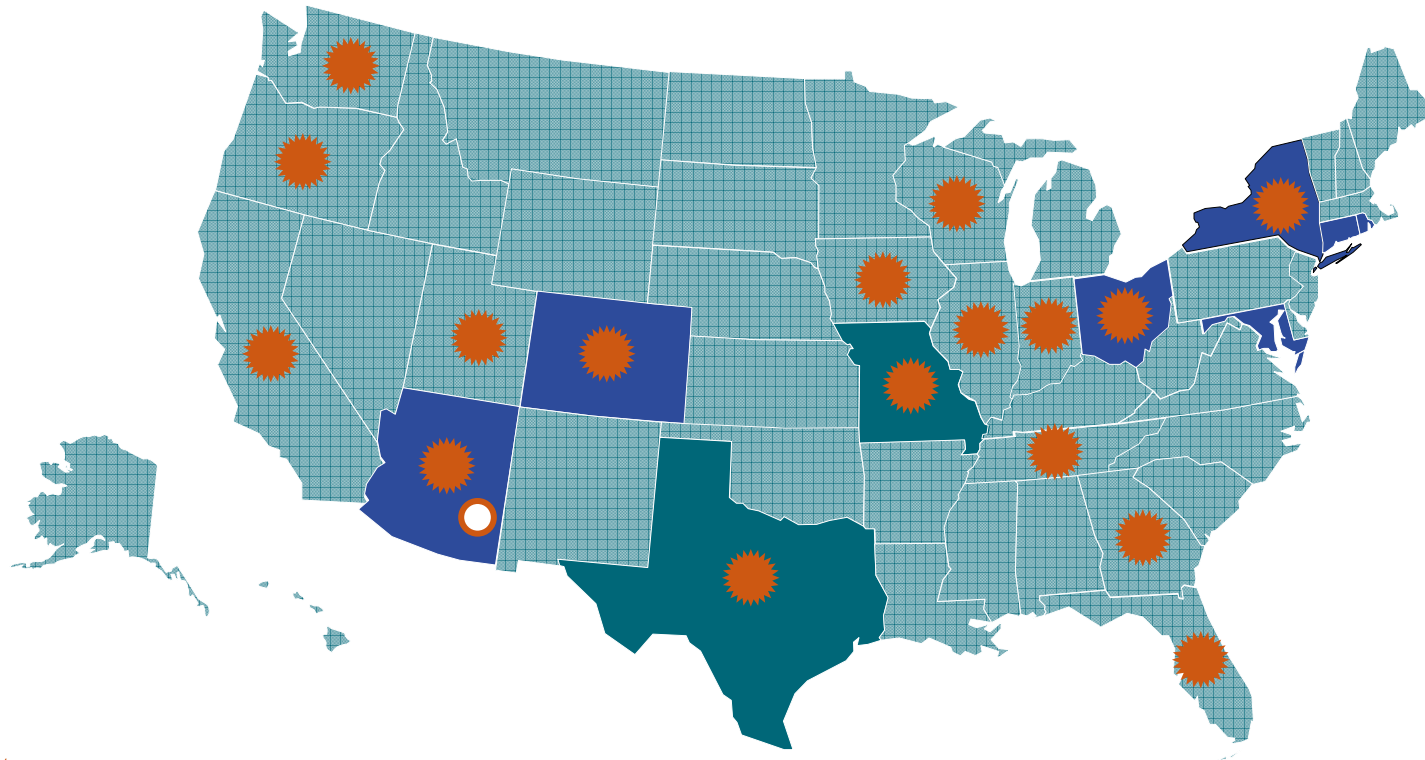
UnitedHealthcare - A more comprehensive and strategic approach

- Key differentiators for UnitedHealthcare's ACO approach:
 - We have well-established, strong relationships between payer and provider
 - We will be selective about our partners to ensure we have aligned goals
 - Our pilots will involve robust reporting on quality & utilization/cost-efficiency to determine actionable items on which ACOs should focus their improvement efforts
 - We have the opportunity to deploy OptumInsight products and tools
 - We will provide clinical support to assist ACOs in developing clinical programs
 - Our product designs will foster member engagement
 - We are an industry leader not only for private, commercial insurance but also for Medicare Advantage, Medicaid and commercial products; we can test our ACO strategy across a varied population

- Current state – Southern Arizona ACO
 - UnitedHealthcare is the payer partner in the Southern Arizona ACO pilot (SAACO)
 - We are participating in the **nationally prominent Dartmouth-Brookings** ACO collaborative
 - Pilot is located in **Tucson, AZ**
 - **Southern Arizona Accountable Care Organization (SAACO)** includes Tucson Medical Center and independent physicians in the community

- Future state – Additional ACO pilots to be active
 - We plan to select 8 – 10 ACO **pilots** in 2011
 - Compiled **candidate list** of additional prospective partners for 2012
 - Leveraging **diagnostic tool** to identify high-potential hospitals and health systems
 - Assess strategic opportunities with the ACO to support **growth**

Current ACO and PCMH activity



 Potential ACO candidates

 UnitedHealthcare current PCMH Pilots

 Planned Dartmouth-Brookings ACO pilot (UnitedHealthcare committed only to AZ)

ACO criteria for success

Key objectives

- Reduce medical costs/trend
- Deliver best possible quality outcomes
- Improve population health and patient experience

Criteria

- Physician leadership and organizational structure
- IT infrastructure
- Care coordination across all care settings
- Robust end-to-end clinical programs
- Proactive care management
- Performance management
- Financial systems and strength
- Shared risk and pay-for-performance experience
- Ability and willingness to accept risk
- Consumer engagement strategies

How UnitedHealthcare supports ACOs

How can we help?

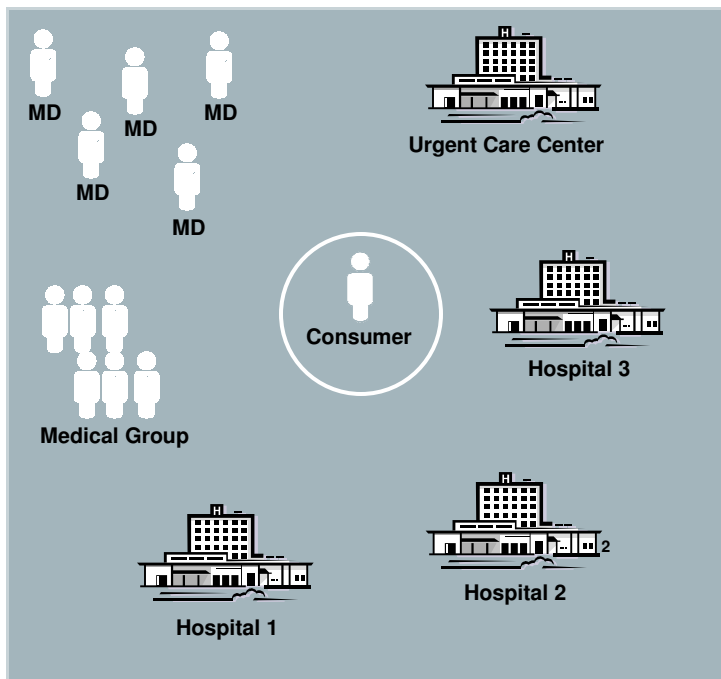
- **Contracting evolution based on provider readiness: (Performance-based contracting → Bundled payments → Risk sharing)**
- **Membership (volume, products, multiple lines of business)**
- **Comprehensive performance measurement and reporting**
- **Mechanism to distribute funds based upon performance**
- **Facilitate access to health information technology**
- **Physician and patient portals; transparency**
- **Member empowerment strategies**
- **Clinical consultation to help improve performance**
- **Robust suite of tools offered by OptumInsight**
- **Option to apply ACO to the delivery system's employee lives as a means of gaining experience and lowering their own health care costs**



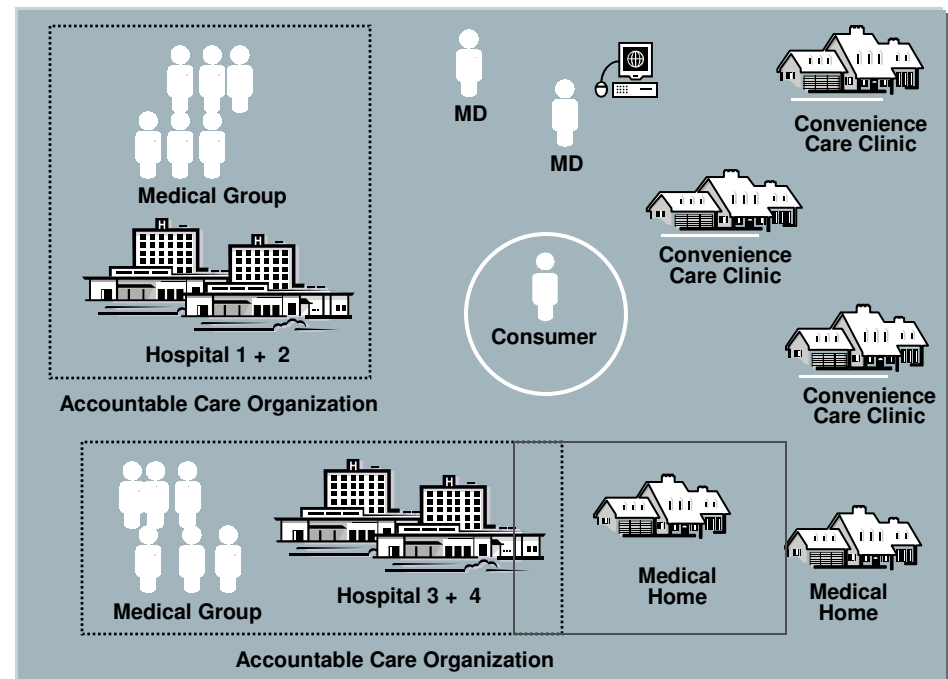
UnitedHealthcare's Patient Centered Medical Home

Delivery System Changes

“OLD” WORLD



“NEW” WORLD



- Delivery and reimbursement models transitioning from ‘pay for activity’ to pay for performance and risk sharing
- Payment and care models that hold providers accountable for the cost and quality of care they deliver
- Formation of coordinated care/ clinical integration across the care continuum – Patient Centered Medical Homes (PCMH) and ACOs

Overview: Patient Centered Medical Home *Defined**

Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care to adults, youth and children.

Principal Characteristics of PCMH:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- Quality and Safety **
- Enhanced Care Access
- Full Value Payment
- Optimization through HIT integration (eRx, patient registry)

The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient's family.

* As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)

** To include a voluntary recognition process by an appropriate non-governmental entity to demonstrate that practices have the capabilities to provide patient-centered services consistent with the medical home model

Pilot Reimbursement Model

This is the primary reimbursement model adapted to each pilot market.

$$\text{FEE FOR SERVICE} + \text{CARE MANAGEMENT PMPM FEE} + \text{PERFORMANCE BONUS} = \text{TOTAL REIMBURSEMENT}$$

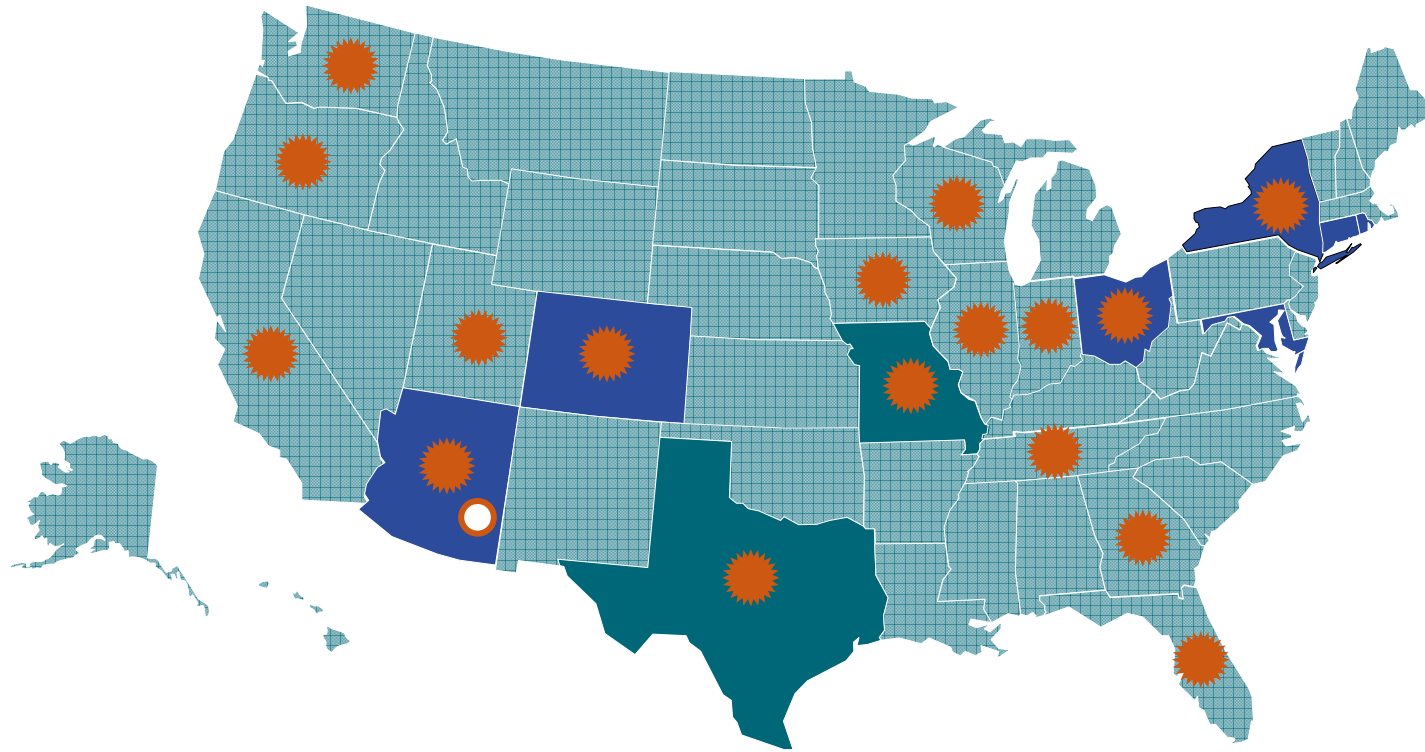
Total Reimbursement builds on the current Fee for Service (FFS) fee schedule with a PMPM Fee and a bonus option based on practice performance.

- Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided
- Quarterly, prospective PMPM supplement based upon quality, efficiency and satisfaction improvements anticipated under the PCMH Model – contract addendum required
- PCMH is grounded in providing more comprehensive, coordinated care and reducing the delivery of services in less efficient settings; it is not about delivering less care to the patient
- Pilot practices are eligible for a quarterly performance bonus that aligns with clearly defined clinical quality, medical cost and operational measures

Reporting: Actionable, Timely and Evidence-Based

Name	Report Overview	Description	Frequency
Panel List	Quarterly practice panel lists	<ul style="list-style-type: none"> This report identifies the specific list of members that attributed to the medical home 	Quarterly
Practice Performance Scorecard	Quarterly Practice Performance Bonus reporting	<ul style="list-style-type: none"> The report assesses and scores the performance of the PCMH pilot practice upon a set of structure, process, and outcomes measures – both clinical and utilization measures are included 	Quarterly
Practice Data Set	Recurring practice data sharing (care gaps, acute event alerts, etc.)	<ul style="list-style-type: none"> These reports alerts the practice and care manager of specific patients that are at high risk, care gaps, have recently visited the ER or hospitalized, need follow-up after discharge, opportunities for referral to Disease or Case Management 	Weekly to monthly, depending on the report
Payment Reports	Quarterly payment funding and bonus level reporting	<ul style="list-style-type: none"> These reports outline the PMPM payment and bonuses earned by each practice 	Quarterly

Current ACO and PCMH activity



 **Potential ACO candidates**

 **UnitedHealthcare current PCMH Pilots**

 **Planned Dartmouth-Brookings ACO pilot (UnitedHealthcare committed only to AZ)**

Program Observations and Early Learning's

Observations

- Practices need to be ready and willing to change
- Need clearly defined, engaged physician and administrative leadership
- Structure alone does not drive outcomes
- Processes need to be adopted and sustained to realize clinical and operational efficiency improvements
- Multi-stakeholder pilots provide the economies for sustainable change

Early Learning's

- Dedicated embedded, care manager and coordination is key to success of overall patient population management
- Two-way data sharing enables better care management actions
- Performance payments can affect change in behavior
- Practice collaboration is key to leveraging best practices
- This is hard stuff which requires heavy lifting.....if there were easy answers, primary care wouldn't be in crisis!

Illustrative example: UHC's Arizona Pilot Program Summary

- ✓ UHC pilot/funding started
- ✓ Process measures in place
- ✓ Transformation plans created and executing
- ✓ NCQA Level 1 submission and achievement
- ✓ Technology procured/advanced and/or implemented (where applicable)
- ✓ Monthly/quarterly reporting started
- ✓ First Learning Collaborative
- ✓ Coordination with hospitalists, specialists and admitting hospitals
- ✓ Data sharing/reporting

Pilot kick off - Feb 2009

- ✓ NCQA Level II and III achievement
- ✓ Chronic care interventions and measures started
- ✓ 2 Learning Collaboratives
- ✓ Hiring on-site Care managers/coordinators
- ✓ Implementing and/or optimizing EMR/eRx
- ✓ Implementing automatic voice reminder systems
- ✓ Increased access and availability through hiring new physicians, office staff, work flow redesign, etc

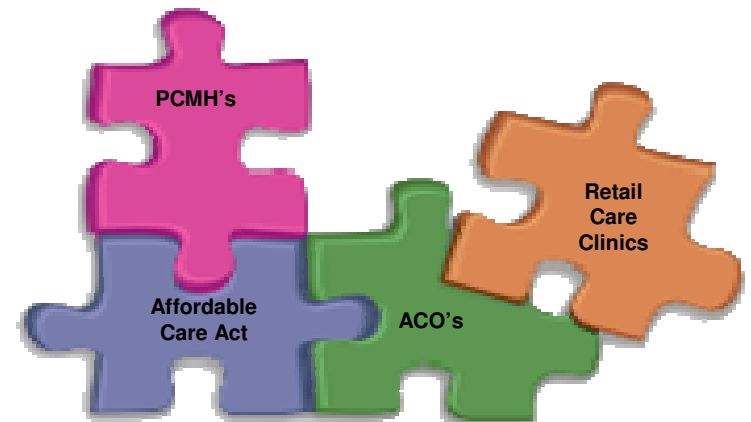
2010

2011

- Completion of Transformation plans
- Updated Care Transitions Questionnaire/Reporting
- Advanced clinical and utilization reporting
- New Clinical Focus: Depression screening
- Advanced pharmacy measures: adherence, poly-pharmacy
- Wrap-up pilot; transition practices and continue to measure

How Convenience Care fits into it all

- Reimbursement
 - FFS
- IT Infrastructure
 - Grow
- Relationships
 - Build
- Valued Services
 - Wellness
 - Preventative
- Consumer Engagement



Thank you for your time today!